Washington State
2006 Health Professional
Scholarship Program

Program located at Washington State Department of Health
310 Israel Road SW ◆ PO Box 47834 ◆ Olympia, Washington 98504-7834

APPLICATION PROCESS

The purpose of the Health Professional Scholarship Program is to provide scholarships to students training to be primary care health professionals. In return the student signs a Promissory Note agreeing to work in a designated health professional shortage area in Washington state for a minimum of three years.

First priority for the 2006-2007 academic year program funds will be given to those applicants enrolled in **Undergraduate Nursing, Nursing Faculty, Dental, Dental Hygienist, and Pharmacist programs** who demonstrate a commitment to rural communities and underserved populations as outlined in the narrative portion of the application. Applicants from remaining eligible health professions (MD/DO: Physician Assistant, Nurse Practioner; Midwife) will be considered based on available funds, applicant pool, and number of providers currently being funded by the program. Award decisions can be expected in June. **All applicants will be notified by mail whether or not they have been awarded a scholarship.**

Applications must include the required attachments**. Incomplete applications will not be processed**. Completed applications must be postmarked no later than **April 28, 2006**.

If you have any questions regarding the application process, contact:

Kathy McVay, Program Manager (360) 236-2816 Kathy.McVay@doh.wa.gov

Chris Wilkins, Program Coordinator (360) 236-2817 Chris.Wilkins@doh.wa.gov

Web site address: www.hecb.wa.gov/health

Applications may be faxed **or** mailed.
Fax Number: (360) 664-9273

2006 Health Professional Scholarship Program Guidelines & Terms of Agreement

ELIGIBILITY

To be eligible, the student must:

- Be accepted into or currently enrolled in an accredited program leading to eligibility for credentialing in Washington State as a physician, osteopathic physician and surgeon, pharmacist, licensed midwife or certified nurse-midwife, physician assistant, nurse practitioner, nurse faculty, dentist, dental hygienist, registered nurse, or practical nurse.
- Have completed prerequisite courses.
- Continue to make satisfactory progress within their academic program.
- Agree to provide primary care health care services for a minimum of three years.
- Be a United States citizen.

SELECTION AND NOTIFICATION

Applicants will be selected for participation in the Health Professional Scholarship Program based on the following criteria but not limited to:

- Prior experience in a rural or shortage area, academic/humanitarian achievements, letters of recommendation, and academic standing.
- Commitment and experience in serving the medically underserved or shortage areas, as described in the narrative portion of the application.
- Preference is given for applicants with community sponsorship and support.
- All applicants will be notified by mail whether or not they are awarded the scholarship.

AWARD AND PAYMENTS

Although scholarship awards are intended to meet the tuition expenses of participants, they are based on availability of state-supported program funds that may not accommodate 100 percent of those expenses.

- The award amount shall not exceed the actual cost of education for the particular program.
- Award notices will be mailed to applicant with amount of award, breakout by semester/quarter, and name of the student's program.
- Checks are mailed to the school approximately two weeks before the beginning of each semester/quarter.
- Student should check with school on the process of how the funds are disbursed.

RENEWAL

- Recipients may renew the scholarship for a period of five years, if they are continually enrolled in an eligible program.
- Scholarship renewal is contingent upon availability of funds for that program year. (The renewal amount may or may not be the same as the initial scholarship amount or the previous year's renewal.)
- **Undergraduate nursing recipients must complete a new competitive application at each program level (i.e., LPN, RN, BSN, MSN).**

SERVICE OBLIGATION

The Scholarship Program can require the recipient to fulfill their service obligation in approved positions in state-designated shortage areas with the greatest need at the time of program completion.

- The length of repayment is determined by the number of years the scholarship is received.
- Participants must serve in a rural or underserved urban area for a minimum of three years.
- The total scholarship amount paid shall be forgiven (canceled) for each payment period (quarter) in which the recipient serves until the entire repayment obligation is satisfied**.**
- Shortage area designations are determined by the Department of Health.

REPAYMENT

Participants who do not fulfill the terms of the Promissory Note will be considered in default and will owe a double penalty plus interest.

A recipient will be considered in default:

- If they do not complete a course of study leading to credentialing in Washington state as a primary care health care provider.
- If they serve less than the minimum three-year service obligation.
- If they do not serve in a designated shortage area (list included with application packet).

The program may waive, in full or in part, the obligation for service or its rights to recover financial damages if the program determines that failure to fulfill the service obligation was due to circumstances beyond the participant's control such as:

- Physical impairment or mental impairment to the degree that the participant can no longer function in his/her assigned duties, or
- The participant's death.

It is your responsibility to read and understand these Guidelines and Terms of Agreement.
If you have questions, please contact our office.
360-236-2816 or 236-2817

Washington State
2006 Health Professional
Scholarship Program Application

Application Deadline: Must be postmarked no later than <u>April 28, 2006</u>

Instructions: Print clearly in ink or type responses. Complete all sections.

Personal

1. Name: _____ _____ ____ **2**. SS #: ____/____/____
Last Name *First Name* *MI*

3. Date of Birth: _____ / ____ / ____ **4**. Driver's Lic. #: _____ State:_____

5. Current Address: _____
Street City State Zip

6. Permanent Address: _____
(If different from current address) Street City State Zip

7. Telephone: (_____)_____ **8**. E-Mail: _____

9. Career needs of spouse (if applicable): _____

10. Your Hometown: _____ Spouse's Hometown: _____

11. Ethnic Origin *(optional)*: _____ **12**. ○ Male ○ Female

13. U.S. Citizen: ○ Yes ○ No *(Must be U.S. Citizen to apply)*

14. Upon completion of training, do you have another service obligation? **Please note, program recipients cannot commit simultaneously to two service obligations.**

○ Yes ○ No If yes, provide details. ○ NHSC ○ IHS ○ Military

○ Other (specify): _____ Date of completion: _____

15. List three adults, including at least one relative, who are not students, who are living at different addresses, and who will know your address in the future. This information will be used in tracking recipients during the service repayment period.

A. Name of Reference One _____ ( ) _____ Phone _____ Relationship to you

Address _____ City _____ State _____ Zip

B. Name of Reference Two _____ ( ) _____ Phone _____ Relationship to you

Address _____ City _____ State _____ Zip

C. Name of Reference Three _____ ( ) _____ Phone _____ Relationship to you

Address _____ City _____ State _____ Zip

Education

Complete those questions that apply.

1. Undergraduate School: _____ **2**. GPA: _____

3. Degree: _____ 4. Date Received: _____ **5**. Years/credits completed: _____

6. Graduate/Professional School: _____ 7. GPA: _____

8. Degree: _____ **9.** Date Received: _____ **10**. Years/credits completed: _____

Program Information

1. Program enrolled in 2006/07: _____
(MD/DO, Physician Assistant, Nurse Practitioner, Dentist, Registered Dental Hygienist, Pharmacy, Midwifery, Licensed Practical Nurse/Associate Degree in Nursing, Registered Nurse, Bachelors of Science in Nursing, Masters of Science in Nursing, PhD)

2. School you will be attending 2006/07: _____

3. School address: _____
Street City State Zip

4. Program start date: _____ Class level in school (2006/07): _____

5. Will you be considered a: ○ Full Time Student ○ Part Time Student

6. Are you applying for this scholarship to become nursing faculty? ○Yes: ○No
If yes, you must complete Question #6 in the Personal/Professional Experience section of this application.

7. Expected date of graduation/program completion: Month: _____ Year: _____

8. Degree/certification expected: _____ Expected License: _____

9. *Indicate the terms **and** number of credits for which you plan to enroll during the **2006/07 scholarship year:*** **Fall** _____ (# credits) **Winter** _____(# credits) **Spring** _____ (# credits) **Summer**_____ (# credits)

10. Will your tuition be covered by another program or tuition waivers? ○Yes: ○No

If yes, program name: _____

Amount provided: $_____Time period covered: _____

This section to be completed by Dean or Director of Program:

Signature of Dean or Director of Program required.

I hereby certify that _____ *has applied to or is officially accepted*
Applicants Name

into the _____ *Program at this school and,*
Name of Program

if a continuing student is academically in good standing.

Student Status is: ○ Full Time ○ Part Time

Signature of Dean/Director of Program	*Title*	*Date*
Printed Name	*Name of School*	
Correspondence Address	*City*	*State* *Zip*
(Area Code) Phone Number	*Fax Number*	*Contact Email Address*

Community Sponsor/Support

Community Sponsor/Support is optional – however, preference will be given to applicants who obtain community sponsor/support. Leave blank if you are not sponsored or expected by a particular community.

- A community sponsor may be a rural hospital, a rural health care facility, a community clinic, or a local health care provider that can provide training or employment opportunities, and post-graduation employment.
- Support should be a financial commitment that may include education/living stipends, matching funds, or employment/training opportunities.
- If there is an individual who expects you to join his or her practice, please provide a name and contact number.

This section is intended to show a commitment to a community with a shortage of primary care health care providers. If this section is completed, it will be expected that the service obligation will be completed in this community.

1. Sponsor *(Clinic, hospital, physician, etc.):* _____

2. Name of contact: _____ **3**. Title: _____

4. Phone: (____) _____ **5.** Fax: (____) _____ **6.** Email: _____

7. Address: _____ **8.** _____
City State Zip County

Describe the type of support this sponsor will provide:

○ Financial Support. Describe: _____

○ Training Opportunities. Describe: _____

○ Employment. Describe: _____

○ Other. Describe: _____

Signature required to receive credit.

Sponsor Certification: I hereby certify the above information is correct and the applicant is receiving the support described above.

_____ _____ _____
Signature of Sponsor/Representative *Title* *Date*

Personal/Professional Experience

(Make brief, concise statements)

1. **Summarize your work/training/practice experience. Comment specifically on your experiences in rural/urban underserved areas.**

2. **Describe your long-range personal and professional goals.**

3. **Discuss your volunteer/professional community service and how it relates to your commitment to serve in a designated rural area/underserved population upon completion of your program.**

4. Describe life experiences you feel make you a good candidate for this scholarship. Include such things as multicultural experiences, languages in which you are fluent, hobbies, interests, etc.

5. Describe your academic/professional achievements that are of particular relevance to this program.

6. If *you plan to become nursing faculty, complete this section.*
NURSING FACULTY: Describe your plans to teach nursing in a Washington State undergraduate nursing program and identify the institution in the space provided below.

Institution: _____ Name of contact: _____

Institution Address: _____
City State Zip

Agreement

I certify that the statements made herein are correct to the best of my knowledge. I authorize the Health Professional Scholarship Program to maintain a record of this information.

I have read the Guidelines and Terms of Agreement and agree to comply with all conditions of the scholarship and understand that I incur an obligation to repay the conditional scholarship with penalty and interest, unless I serve for a minimum of three years as a primary health care provider in a designated rural, underserved urban, or other health professional shortage area in the state of Washington. **I understand that, at the time of program completion, I can be required to complete my service obligation in the shortage area with the greatest need at that time.** I agree to accept Medicare assignments and Medicaid patients.

Signature of Applicant: _____ Date: _____

Attachment Checklist

○ Signature of Dean or Program Director or letter of acceptance with Dean or Program Director signature. ***(Required)***

○ Three recommendation letters from training supervisors/professional colleagues. ***(Required)***
To be used in the review and selection process to determine experience and commitment in working with rural and underserved urban populations. Letters should be from community leaders, faculty, training supervisors, and/or professional colleagues who can attest to your knowledge, commitment, and ability to fulfill the scholarship obligation. Include with your application packet.

○ Academic transcript(s). ***(Required)*** *Photocopy acceptable.*
Applicants who have completed a year or more of health professional education/training should submit transcripts only for those years. Applicants entering the first year of health professional education/training should submit undergraduate or prior college-level transcripts.

○ Signature of sponsor. ***(If applicable)***
If you completed the Community Sponsor/Support section, a signature is required to receive credit.

Mail Completed Application and Required Attachments To:

Health Professional Scholarship Program
Office of Community and Rural Health
310 Israel Road SW
PO Box 47834
Olympia, WA 98504-7834

For information, contact program staff at:

Telephone:360-236-2816 or 360-236-2817
E-Mail: Kathy.McVay@doh.wa.gov
Chris.Wilkins@doh.wa.gov
Fax: 360-664-9273

APPLICATION MUST BE POSTMARKED NO LATER THAN APRIL 28, 2006

State of Washington

Health Professional Scholarship Shortage Areas

January 2006

Institutions

Health Professional Scholarship recipients may locate at any of the following in Washington state:

- State Correctional Facilities
- State Mental Health Hospitals
- Community and Migrant Health Centers (Federally-Qualified Health Centers)
- Any other facility (public, non-profit, or private) with more than 40 percent of its caseload consisting of Medicaid and sliding-fee discount schedule patients.

Shortage Areas by Profession

There are no geographic restrictions for practical or registered nurses at this time.

All scholarship recipients must be employed in direct primary care and not in a specialty clinic.

Nursing faculty must work a full-time equivalent in a combination of faculty and clinical positions in Washington state. Faculty positions must be in a Washington state undergraduate nursing program that is experiencing a critical shortage of qualified faculty.

Shortage areas for the other professions are listed in the following table divided between Western and Eastern Washington.

** (The University of Washington WWAMI Rural Health Research Center developed Health Service Area [HSA] boundaries. HSAs are collections of zip codes surrounding a core health facility such as a hospital or local public health department.)*

HEALTH PROFESSIONAL SCHOLARSHIP SHORTAGE AREAS
January 2006

Western Wash. *Health Service Areas	MD/DO	DDS	RDH	Rx	PA	NP	MW
Arlington					PA	NP	MW
Centralia		DDS		Rx	PA	NP	MW
Concrete	MD/DO		RDH	Rx	PA	NP	MW
Darrington		DDS					
Eatonville	MD/DO	DDS	RDH	Rx	PA	NP	MW
Enumclaw			RDH	Rx	PA	NP	MW
Forks		DDS	RDH	Rx	PA	NP	MW
Gold Bar	MD/DO	DDS		Rx	PA	NP	MW
Key Peninsula					PA	NP	MW
Longview				Rx	PA	NP	MW
McCleary	MD/DO	DDS	RDH	Rx			
Monroe					PA	NP	MW
Morton		DDS	RDH	Rx	PA	NP	MW
Mount Vernon				Rx	PA	NP	MW
North Bend	MD/DO	DDS		Rx	PA	NP	MW
Olympic Peninsula			RDH		PA	NP	MW
Orting	MD/DO	DDS	RDH	Rx			
Port Angeles					PA	NP	MW
Port Townsend				Rx	PA	NP	MW
San Juan Islands				Rx	PA	NP	MW
Shelton	MD/DO	DDS	RDH	Rx	PA	NP	MW
South Bend	MD/DO	DDS	RDH	Rx	PA	NP	MW
Sumas/Mt. Baker	MD/DO	DDS	RDH	Rx	PA	NP	MW
Yelm	MD/DO		RDH	Rx			

Eastern Wash. *Health Service Areas	MD/DO	DDS	RDH	Rx	PA	NP	MW
Brewster		DDS	RDH				
Chewelah	MD/DO	DDS	RDH	Rx			
Clarkston	MD/DO	DDS	RDH		PA	NP	MW
Colfax					PA	NP	MW
Colville				Rx			
Coupeville		DDS	RDH	Rx	PA	NP	MW
Davenport		DDS					
Dayton	MD/DO	DDS					
Deer Park	MD/DO	DDS	RDH	Rx	PA	NP	MW
Ellensburg				Rx			
Ephrata	MD/DO	DDS	RDH		PA	NP	MW
Goldendale		DDS	RDH	Rx	PA	NP	MW
Grand Coulee			RDH	Rx	PA	NP	MW
Ilwaco	MD/DO	DDS	RDH	Rx			
Ione/Metaline Falls	MD/DO	DDS	RDH	Rx	PA	NP	MW
Leavenworth		DDS		Rx	PA	NP	MW
Moses Lake				Rx			
Newport	MD/DO	DDS	RDH	Rx	PA	NP	MW
Odessa		DDS	RDH		PA	NP	MW
Omak			RDH		PA	NP	MW
Othello	MD/DO	DDS	RDH	Rx	PA	NP	MW
Pomeroy	MD/DO						
Prosser	MD/DO	DDS	RDH	Rx	PA	NP	MW
Pullman		DDS					
Quincy	MD/DO	DDS		Rx	PA	NP	MW
Republic	MD/DO		RDH	Rx	PA	NP	MW
Ritzville	MD/DO		RDH	Rx	PA	NP	MW
Sunnyside			RDH	Rx	PA	NP	MW
Tonasket		DDS	RDH	Rx			
Toppenish		DDS	RDH	Rx			
Wenatchee					PA	NP	MW
White Salmon	MD/DO	DDS	RDH	Rx	PA	NP	MW

MD/DO	**Physician**
DDS	**Dentist**
PA	**Physician Assistant**
RDH	**Registered Dental Hygienist**
NP	**Nurse Practioner**
Rx	**Pharmacist**
MW	**Midwife**